



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
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March 3, 2009

RECEIVED

MAR 17 2009

Mr. Torrey Bollinger
Preferred Community Homes - Vineyards
7091 West Emerald Street
Boise, ID 83704

FACILITY STANDARDS

RE: Preferred Community Homes - Vineyards, Provider #13G028

Dear Mr. Bollinger:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Vineyards, which was conducted on February 23, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **March 16, 2009**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by March 16, 2009. If a request for informal dispute resolution is received after March 16, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MATT HAUSER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MH/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/23/2009
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - VINEYARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 2226 WEST SONOMA DRIVE MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your annual recertification survey. The survey was conducted by: Matt Hauser, QMRP, Team Leader Jim Troutfetter, QMRP Common abbreviations/symbols used in this report are: IPP - Individual Program Plan 483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate general and preventative medical care was provided to 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed. This resulted in unclear information regarding which as needed medications individuals should receive. The findings include: 1. Individual #1 - #3's routine standing orders included the following: - Tylenol (a nonopioid analgesic drug) to be given every 4 hours as needed for pain or fever. - Ibuprofen (a nonsteroidal anti-inflammatory drug) to be given every 4 to 6 hours as needed for fever or pain. It was not clear which drug (Tylenol or Ibuprofen) was to be given to the individuals if they had a	W 000	Preparation and implementation of this plan of corrections does not constitute admission or agreement by Vineyards with the facts, findings, or other statements as alleged by the State agency dated February 23, 2009. Submission of this plan of correction is required by law and does not evidence the truth of any of the findings as stated by the survey agency. Vineyards specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action. W322 483.460(a)(3) PHYSICIAN SERVICES All Individual's RSO's will and have been individualized and we are working on obtaining physician's signatures. As for the Tylenol and Ibuprofen issue - "Per Nursing Judgment" will be on all the RSO's and we will also make sure that if anyone cannot tolerate either medication, it is noted on their orders. Person Responsible: House Nurse Monitored: monthly Completion date: 3-11-09 (with the exception of those still waiting on Dr.'s signatures)		
W 322		W 322			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 322	<p>Continued From page 1 fever or were in pain.</p> <p>Individual #1 - #3's routine standing orders also included the following:</p> <ul style="list-style-type: none"> - Milk of Magnesia (a laxative drug) to be given as needed for constipation. - Bisacodyl (a laxative drug) suppository to be given as needed for constipation. <p>It was not clear which drug, Milk of Magnesia or Bisacodyl suppository, was to be given to the individuals for constipation.</p> <p>When asked about the orders, the Administrator stated, on 2/24/09 at 11:15 a.m., that Milk of Magnesia would usually be used prior to suppositories being given. He further stated that the orders needed to be clarified.</p> <p>Individual #1 - #3's routine standing orders also included the following:</p> <ul style="list-style-type: none"> - NIX (a pediculicide topical drug) as needed for lice. <p>When asked about the use of NIX, the Administrator stated on 2/24/09 at 11:17 a.m., none of the individuals residing at the facility had lice for at least 3 years.</p> <p>The facility failed to ensure follow up with the physician occurred in order to clarify which as needed drugs Individuals #1 - #3 should be receiving.</p>	W 322			
W 388	<p>483.460(m)(1)(i) DRUG LABELING</p> <p>Labeling for drugs and biologicals must be based on currently accepted professional principles and</p>	W 388			

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W 388	<p>Continued From page 2 practices.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure all medications were correctly labeled for 3 of 6 individuals (Individual #1, #2, and #4) that received Miralax. This resulted in the potential for medication administration errors and subsequent negative impacts to the individuals. Findings include:</p> <p>1. Individual #1's 2/3/09 IPP documented a 38 year old male whose diagnoses included profound mental retardation and chronic constipation.</p> <p>During a medication observation from 8:18 - 8:40 a.m. on 2/18/09, Individual #1 was noted to receive Miralax (a laxative drug). The Miralax container did not have a pharmacy label, and did not include the dosage or time he was to receive the drug.</p> <p>Individual #1's Physician's Order, dated 12/08, stated he was to receive 30 cc of Miralax one time daily at 8 a.m.</p> <p>2. Individual #2's 9/24/08 IPP documented a 45 year old male whose diagnoses included profound mental retardation and a history of constipation.</p> <p>Individual #2's Physician's Order, dated 12/08, stated he was to receive 30 cc of Miralax mixed with fluid or food twice daily at 8 a.m. and 8 p.m.</p> <p>The Miralax container did not have a pharmacy</p>	W 388	<p>W388 483.4609(m)(1)(i) DRUG LABELING</p> <p>All individual's medications are labeled. We will ensure all OTC medications that are prescribed for use on a daily basis come from the pharmacy and are labeled for the individual.</p> <p>Person Responsible: House Nurse Monitored: monthly Completion date: 3-11-09</p>		

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W 388	<p>Continued From page 3</p> <p>label, and did not include how many daily dosages Individual #2 was to receive or the specified times he was to receive the drug.</p> <p>3. During a medication observation on 2/18/09 from 7:52 - 8:17 a.m., Individual #4 was noted to receive Miralax. The Miralax container did not have a pharmacy label, and did not include the dosage or time Individual #4 was to receive the drug.</p> <p>When asked about Miralax not having pharmacy labels, the facility Registered Nurse stated, on 2/24/09 at 10:59 a.m., that she understood the need for pharmacy labels for drugs ordered by a physician and used daily by individuals.</p> <p>The facility failed to ensure all drugs were labeled according to professional practice.</p>	W 388			

Bureau of Facility Standards

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MM271	<p>16.03.11.100.04(b) Storage of Toxic Chemicals</p> <p>All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all toxic chemicals were stored under lock and key for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. The findings include:</p> <p>1. An environmental review was conducted on 2/19/09 from 2:40 - 3:30 p.m. At that time, the following toxic chemicals were noted to be unlocked on a storage shelf in the garage:</p> <ul style="list-style-type: none"> - No less than three 1.5 gallon bottles of Chlorox Bleach. - No less than 4 containers of Comet. - Three containers of Liquid De-icer. - Two quart containers of Lighter fluid. <p>The Home Manager was present during the entire environmental review and stated that the chemicals had been stored like this for years. The Home Manager immediately placed the above items in a locked storage area.</p> <p>The facility failed to ensure all toxic chemicals were in appropriate areas under lock and key.</p>	MM271	<p>MM271 16.03.11.100.04(b) Storage of Toxic Chemicals</p> <p>All toxic chemicals are labeled and stored under lock and key.</p> <p>Person Responsible: House RSC Monitored: daily Completion date: 3-11-09</p>		
MM735	<p>16.03.11.270.02 Health Services</p> <p>The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered</p>	MM735	<p>MM735 16.03.11.270.02 Health Services</p> <p>Refer to W322</p>		

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MAR 17 2009

FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

ZBYY11

TITLE

Administrator

(X6) DATE

2/16/09

If continuation sheet 1 of 2

Bureau of Facility Standards

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MM735	Continued From page 1 must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735			